PRE & IN-SERVICE
FAMILY PLANNING TRAINING STRATEGY FOR SINDH
(2016-2020)

Population Welfare Department |Department of Health |PPHI |Development Partners

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List of Abbreviations

1	ATP	Annual Training Plan
2	CIP	Costed Implementation Plan
3	CMO	Chief Medical Officer
4	CPR	Contraceptive Prevalence Rate
5	DoH	Department of Health
6	EDP	External Development Partners
7	FWC	Family Welfare Center
8	HTSP	Healthy Timing & Spacing in Pregnancy
9	HRD	Human Resource Development
10	IUCD	Intrauterine Contraceptive Device
11	INGO	International Non-Governmental Organization
12	LHW	Lady Health Worker
13	LHV	Lady Health Visitor
14	MO	Medical Officer
15	MWRA	Married Women of Reproductive Age
16	MSU	Mobile Service Unit
17	NGO	Non-Governmental Organization
18	PPHI	Peoples Primary Healthcare Initiative
19	PWD	Population Welfare Department
20	PTCC	Provincial Technical Coordination Committee
21	PHDC	Provincial Health Development Center
22	PWTI	Population Welfare Training Institute
	RHCS	Reproductive Health Commodity Security
23	RTI	Regional Training Institute
24	RHS A	Reproductive Health Services A Center
25	SDGs	Sustainable Development Goals
26	TNA	Training Need Assessment
27	UNFPA	United Nations Fund for Population Activities (United Nations Population Fund)
28	WMO	Women Medical Officer

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Executive Summary

Sindh has a population of 46 million and at estimated fertility level of 3.9(PDHS 2012-13) it is expected to reach to 50 million by year 2020[1]. The province has a bulk of young population.As per population estimates, in 2010, fifty-seven percent of the population was less than age of 30, of which, around 20.4 percent were between ages of 15 and 24[2]. Moreover, there has been slow progress on key family planning indicators in Sindh.

In the above context, three concerns are distinct; these concerns indicate aneed for a properly qualified and skilled human resource. These concerns include: accelerated efforts to provide services on equitable grounds with a rights based approach; need to focus on areas with high unmet need; and the services have been affected because of poor quality of care concerns indicating a need for qualified and skilled staff.

At present, Pakistan is a signatory to two major international commitments that are related to family planning i.e. FP2020 and Sustainable Development Goals – the former being directly related to family planning, and the latter, containing at least one goal related to health and population issues. These commitments can be achieved through skilled and dedicated staff. The draft Population Policy document also emphasizes capacity building.The Health Sector Strategy re-defines links with PWD by provision of FP services through district and urban primary healthcare.

The Costed Implementation Plan for the province gives special attention to ensure quality of services through enforcement of FP Standards and imparting training on an extensive scale.

Apart from having policy and planning documents, both the departments have a network of facilities and sizeable number of staff. The PWD has total staff strength of 10,597 across the province. That include staffs at head office; regional directorate; Population Welfare Training Institute; RTIs; District offices; Taluka offices; FWCs; MSUs, RHS; MPSBs; and social mobilizers.

The Department of Health currently employs 21,042 doctors/specialists; 2,628 nurses; 894 LHVs; 40,000 paramedics; 1705 CMWs; 22,575 LHWs and 770 Lady Health Supervisors.

The Development partners are supporting FP initiatives in the province through selected INGOS, and NGOs. Some of the key INGOs/NGOs providing FP services include Jhpiego/MCHIP; Greenstar Social Marketing; Mariestopes Society; Aman Foundation/Sukh Initiative; Family Planning Association of Pakistan (Rahnuma FPAP); Indus Hospital; HANDS; Merlin; IHS; and others.

The Departments of Health and Population have established a number of institutions for the trainings these include:

- Population Welfare Training Institutes (PWTI)
- Regional Training Institutes (RTIs)

[2]Population Welfare Department, Government of Sindh, *Costed Implementation Plan on Family Planning For Sindh (2015-2020)*, Sindh, Pakistan: Population Welfare Department; December 2015; page 8

- RHS Master Training Centers
- Provincial Health Development Center (PHDC)
- District Health Development Center (DHDC)
- Nursing School
- Public Health Schools

There are certain strengths, opportunities and challenges that have implications for training initiatives. Before developing a way forward it is pertinent to briefly go through the main strengths, opportunities and challenges.

The Department of Population Welfare has strong institutional mechanisms for training. For example, PWTI and RTIs are important institutes for training of human resources from within the Department as well as outside of the department. DoH has PHDC as its prime institute for training of medical officers and other staff. Many districts have DHDCs that provide trainings at districts level. Other positive aspects are functioning Public Health Schools, Nursing Schools etc.

In post devolution period, several new steps and initiatives have been taking place which present promising opportunities for effective training plans. For example, draft Population Policy; Costed Implementation Plan (CIP) and already adopted Manual of FP Standards are some of the leading documents now available to the province.

Apart from strengths there are some challenges as well that are outlined as under:

- Trainings are being conducted mostly in vertical manner without integrating them into horizontal manner linkages between pre & in-service trainings; coordination between different stakeholders
- Trainings lack keeping pace with recent developments and modern techniques in a systematic way.
- There seems a disjoint between pre and in-service training
- Are there different training programs and curricula for different categories of health providers?

The objectives of the Strategy include:

- To streamline the trainings so as to significantly contribute towards:
    - Enhancing CPR from existing 30% up to 45% by the year 2020
    - Reducing unmet need from existing 21% to 14% by 2020 and increasing the met need (demand) of the population
    - Delivering quality contraceptives at 80% facilities by 2018 by skilled human resources
    - Reducing stockouts of contraceptives in health facilities
- To enhance competency based skills through pre-service, in service trainingsto deliver quality services on equitable basis with rights based approach
- To standardize the curriculum at pre and in-service stages within public and private sectors
- To undertake impact assessment of trainings; conduct TNA based on findings of the impact assessment; and translate those results into Annual Training Plans
- To strengthen monitoring, evaluation, supportive supervision and feedback mechanisms so that intended outcomes of trainings are ensured

- To develop career development plans for each category of staff
- To include family planning components by revising existing curricula so that each related category of staff gets theoretical and practical training on method mix; counseling; rights based approach and communication skills
- Building upon per-service training and induction training, develop an integrated training mechanism that enhances skills based on standardized curricula in continuation of pre-service training. The training would maintain balance between theoretical and practical components; would include method mix; counseling; right based approach and communication skills etc.

Based on the overall context of the population and health sectors reforms at levels of pre and in service trainings have been suggested in this strategy. Following is a brief on those reforms in the areas of policy, institutions, curricula, faculty, public private partnership and M&E:

Reforms suggested under the Strategy

Policy & planning

- Implementing 'Task Shifting' approach through necessary trainings starting with LHWs, CMWs, FWW and LHVs (LHWs to administer first injection while CMWs, FWW, LHVs to insert implanon
- Integration of pre & in-service trainings moving towards career development plans

Institutional

- Revamping Training related Wings, Units at PWD, DoH to enable them to deliver under new realities and challenges

Curriculum

- Introducing robust mechanism of "accreditation" by revising the existing mechanisms of certification of trainings
- Focusing on skills development rather than mere knowledge of theoretical concepts
- Linking training courses with the system of "credit hours" and information technology
- Revising curricula at various levels specifically revision of medical curriculum to introduce family planning component in sufficient detail and mandatory exam components

Faculty

- Capacity building of faculty on new techniques of teaching (adult learning methodology) and new approaches in family planning

Public Private Partnership

- Standardization of curriculum and making it uniform across the public and private sectors following the Manual on FP Standards

Monitoring & Supportive Supervision

- Emphasizing on conducting Training Need Assessments (TNA) as an in-depth exercise and develop 'Annual Training Plans' according to TNA
- Promoting research activities on human resource development by each training institution and presenting the findings at various forums organized for the purpose and translating them into decision making (by promoting Operational Research and Implementation Research)

Section – 1 INTRODUCTION & METHODOLOGY

1.0 INTRODUCTION & METHODOLGY

Pakistan launched its family planning programs around 60 years back. Six decades down the road,still it has highest growth rate (2%) and lowest CPR (35%) within the region.The country is 6th most populous in the world which potentiallymeans prevalence of more poverty, illiteracy, unemployment, crime, extremism and violence pushing back the pace of economic development. As a result, the country ranks 147 out of 188 countries as per Human Development Report 2015[3]. This situation may be turned around with persistent efforts and the response if simply put is - Population Development. The population development was at the core of the program when it was initiated in early 60s. One of the advertisements as part of mass awareness on family planning appeared on Feb 28, 1965 in daily Dawn showing a mother and her child. It says:"nourishing food, happy surroundings; proper care; good education are the basic ingredients of a bright future. But too many children are an obstacle in the fulfillment of her dreams. Above all children born at short intervals will not be strong and healthy"[4]..

The body of knowledge and skills is dynamic - ever expanding and changing - as new information is evolving and made available through research, proven and best practices. Socio-cultural changes and environmental factors continue to influence priorities in health & population sectors which are then reflected through programs. To stay abreast of changing circumstancesis an imperative and should be a routine of every healthcare system. In some domains, programs are carefully stipulated, strongly mandated and stringently regulated and enforced.[5]

A major pre-requisite for providing quality healthcare service is upgrading the skills and knowledge of all health personnel as well as key personnel of related sectors. The training plan needs to be prepared keeping in view the existing functional facilities, and services being provided at those facilities.[6]

In the above context, it is worth mentioning that the Population Welfare Department (PWD), Sindh, normally follows a set pattern for the training and the Department of Health also has similar institutional mechanisms for the training of its cadres. Annual Training Plans are being developed in

[3]UNDP. Human Development Report, 2015
[4]Daily Dawn. February 28, 1965
[5]Ministry of Health & Social Welfare, Liberia. 'Strategy for National In-Service Education', December 2009
[6]Ministry of Health and Family Welfare, India. 'National In-Service Training Strategy 2005-12'

terms of Population Welfare Training Institutes; Regional Training Institutes (RTIs) of PWD and Provincial Health Development Centers (PHDC); Public Health Schools under the DoH. The Population Welfare Training Institute (PWTI) starts the exercise with an in-house meeting of faculty to ascertain training needs. Based on that in house meeting, a draft Annual Training Plan (ATP) is prepared. The draft is then discussed at a Committee constituted by PWD and same is revised accordingly. A revised draft is re-considered and approved. Allocations are made under the current budget.

1.1 Training Approaches: National/International Experiences

The fundamental premise for the Training Strategy is that quality of services is compromised due to lack of or shortage of trained and skilled human resource in the public and private sectors. In case quality services are available in private sector, these are non-affordable to the women of reproductive age who are poor and living in rural and remote areas. They tend to avail low quality services from poorly trained or unskilled human resources, thus resulting in inequities and slowing the pace of decrease in unmet need. Ultimately, it becomes difficult to ensure improvement in outcome indicators i.e. CPR; TFR; growth rate.

Before discussing further on training/capacity development,it is important to look at family planning from a holistic perspective. Modern theories of fertility suggest that contraceptive use enhances with increasing income and higher levels of education. The variables like household income, female employment, literacy, maternal mortality and infant mortality are clearly linked to fertility through contraception. Where ever, these variables are negative or show poor progress, results of any program will be unpredictable.[7]

We know from evidence that poverty and lack of education further aggravate the level of ignorance regarding benefits of contraception, which also exacerbates the ability of providers to properly counsel the uneducated, poor married women of reproductive age (MWRA). 'Negative or incorrect perception of family planning methods and their usage are primarily based on the lack of proper information, or disinformation in general about these methods coupled with high degree of illiteracy. Specifically, methods like IUD insertion have received added bad publicity because of the insufficient attention given to these methods during counseling sessions, and insufficient provider experience.'[8]

There are other factors as well that draw attention toward capacity building needs. For instance, 'there is constant flow of new evidence that requires development of new techniques, technology, and knowledge and approaches .... quality of care largely depends on the quality, skills and competence of providers. Upgrading and updating their skills will be done to enhance the quality of care..... work force performance depends not only on a variety of factors including capability (knowledge, skills),

[7] Warren C. Robinson. 'Family Planning in Pakistan 1955-1977: A Review ', Pakistan Institute of Development Economics, 1978

[8] Aneela Sultana et al. Factors associated with failure of family planning methods in Pakistan: Burhan Village case study, Working paper series # 91, SDPI, 2004

opportunity (resource), and motivation (incentives) but also a wide range of contextual factors: expectations communicated to them by supervisors, health facility infrastructure, client flow, use of space, organization of work etc.[9]

The evidence shows that there is strong link between appropriately trained human resource and quality of service provision. And that service provision further worsens in case non-affordability, low access and low usage of services due to poverty and illiteracy is coupled with unskilled staff with poor or no training.

1.2 METHODOLOGY

This strategy has been developed based on a technical assistance (TA) provided to the Population Welfare Department of Sindh by the United Nations Population Fund (UNFPA). The objective of the exercise is to provide technical support to PWD Sindh in formulation of a FP Training Strategy while taking into account all dimensions of performance related to family planning in public and private sector. The Strategy is expected to provide a framework for the government of Sindh and relevant External Development Partners (EDPs) to allocate resources for the concerned departments and training centers/ institutes to systematically implement capacity building activities for family planning service providers.

For the purpose of development of the Strategy, following instruments have been used:

- Desk review of literature and review of existing training strategies
- 2 Consultative Workshops with public and private sector partners
- Individual meetings with key informants
- Meetings with selected partner organizations in private sector
- Meetings with public sector organizations (PWTI, RTIs, PHDCs, DPWOs (2-3), hospitals (2-3)

Open ended questionnaires were used for individual meetings and a set of exploratory themes has been used for consultative workshop to gather information.

1.3Structure of the Strategy

This is the Final Draft of the Strategy. First draft was shared during 1st Consultative Workshop in December 2015. 2nd Draft was shared before 2nd Consultative Workshop held June 17, 2016. 3rd Draft was shared based on feedback provided during 2nd Workshop. This final Draft is based on inputs/feedback during the whole process and is submitted to PWD and UNFPA for further process.

Based on strengths, opportunities and challenges, two separate matrices on Pre Service and In Service Training are provided outlining the policy approaches, strategies, objectives, main outputs etc. Those will be utilized to transform into routine Annual Training Plans of the Departments thus, clearly aligning this document with the officially available channels/instruments/tools which would ensure sustainability of this Strategy.

Summary of Structure of the Strategy

EVIDECNE	Strengths, Opportunities,	Pre & In service Training Strategy

[9]USAID. Nepal Family Health Program II, Technical Brief # 32 'Improving health workers performance through in-service training (www.nfhp.org.np)

Capacity development needed to ensure: -Quality -Equity -Addressing unmet need	**Challenges in terms of policy planning; institutional mechanisms; Curriculum; faculty; partnerships; M&E** -Policy (CIP, FP2020, SDGs), institutional (strong institutional channels/PWTI, RTIs), curriculum (FP Standards, Modules), faculty, M&E, public private partnerships -Weak areas in trainings	**based on HRD Reforms** Making curriculum in line with FP Standards; trained HR in rural and remote areas to cater to poorest of the poor; more skills in IPC, counseling, rights based approach; training of facility based staff to tap unmet need and other reforms) etc.

SECTION - 2 THE CONTEXT: QUALITY; EQUITY/RIGHTS BASED APPROACH; AND UNMET NEED

THE CONTEXT: QUALITY; EQUITY/RIGHTS BASED APPROACH; AND UNMET NEED

2.1 Demographic Parameters

Sindh has a population of 46 million, and at the estimates based on current fertility level (PDHS 2012-13) it is expected to reach to 50 million by year 2020[10]. As per UN's definition of youth[11], the province has a large youth population, between the ages of 15 and 24. In 2010, 57 percent of the population was less than the age of 30, of which around 20.4 percent were in the age range of 15 through 24 years. Projections (medium term) reveal that by 2020, 52 percent of the population will be less than 30 years and 19.1 percent between ages 15 – 24 years[12]. This bulk of young population, that may become source of higher growth rate, will require special attention at service delivery level whereby quality services should be provided with trained human resource.

There has been slow progress on key FP indicators in Sindh (table 2.1). For example, total fertility rate (TFR) reduced by only 1% over the past 25 years. The increase in CPR has been 17 percentage points (from 12.4% to 29.5%), during the same period. Unmet need has been decreasing slowly from around 24% in 1990-91 to 21% in 2012-13. Although, population and health sectors are striving to improve the indicators, there is need for extra efforts for achieving provincial policy objectives as well as international commitments. In this regard, qualified, skilled and dedicated human resource is crucial for ensuring results.

Table2.1: Key Indicators related to FPRH for Sindh

Indicators	PDHS1990-91 (%)	PDHS 2006-07 (%)	PDHS 2012-13 (%)
TFR	5.1	4.3	3.9
CPR	12.4	26.7	29.5

[10]Population Welfare Department, Government of Sindh, *Costed Implementation Plan on Family Planning For Sindh (2015-2020)*, Sindh, Pakistan: Population Welfare Department; December 2015

[11]http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf

[12]PWD. Population Policy of Sindh and 'Population projections for Sindh and Pakistan 2010-2050 prepared for M&E Working Group, USAID MCH program Sindh, July 2014

mCPR	9.1	22.0	24.3
% teenage births (≤18)	12.0	8.3	7.9
Proportion women want no more births	35.8	48.4	51.2
Unmet Need	23.9	25.4	20.8
IMR	91	78	74

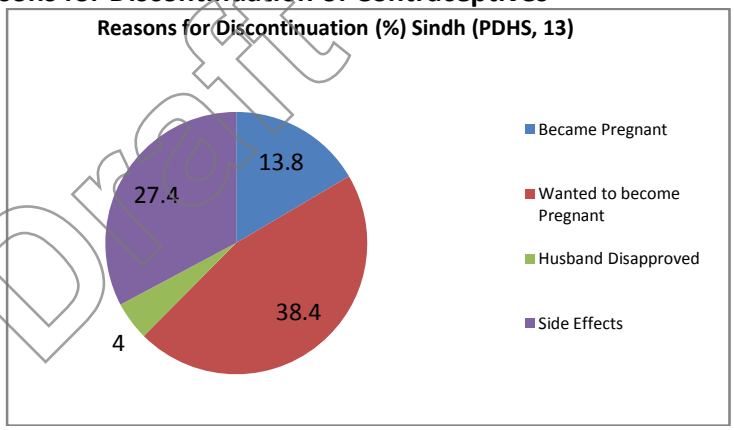
Source: PDHS and PRHFPS through Costed Implementation Plan 2015-20

2.2 Quality, Equity and Un-met Need

While assessing available data, three concerns are distinct, all these concerns point towards a need for a properly qualified and skilled human resource. These concerns include: accelerated efforts to provide services onequitable grounds; rural, remote areas remain with high unmet need; and the services are marred with quality concerns indicating towards more need for qualified and skilled staff.

Pakistan Demographic and Health Survey 2012-13 has provided some insight into how issues related to qualitymay undermine access to FP uptake. As per the data, more than one fourth (27.4%) women interviewed reported that they could not continue with contraception due to the side effects (Figure 2.1).

Figure 2.1: Reasons for Discontinuation of Contraceptives



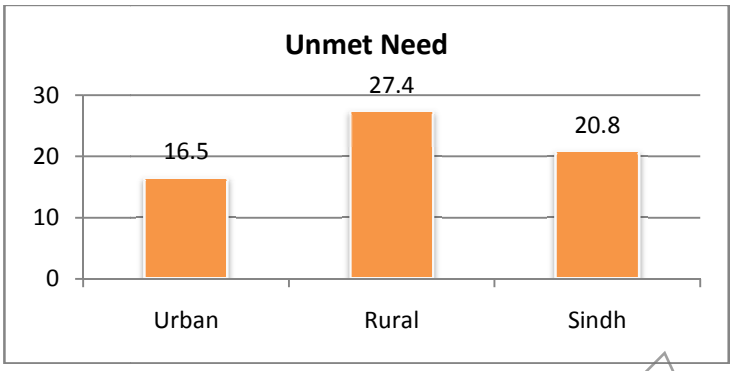
Source: PDHS 2012-13

The issue of side effects indicates towards lack of standardized services in terms of facilities, supplies and human resource. The providers' poor counseling skills are also one of the reasons for discontinuation since in many cases women are not informed about possible side effects of the methods.

There is around 21% of unmet need in Sindh with even higher unmet need in rural and remote areas (Fig 2.2). As per PDHS data, rural and remote areas have unmet need of 27.4% as compared to urban areas where unmet need is estimated at 16.5%. One of the reasons for this high unmet need in rural as well as

urban areas suggests that there may be shortage of outreach as well as facility level staff or they may not be properly skilled. In addition, availability of commodities at last mile has been hampered resulting into stock outs and poor capacity of forecasting.

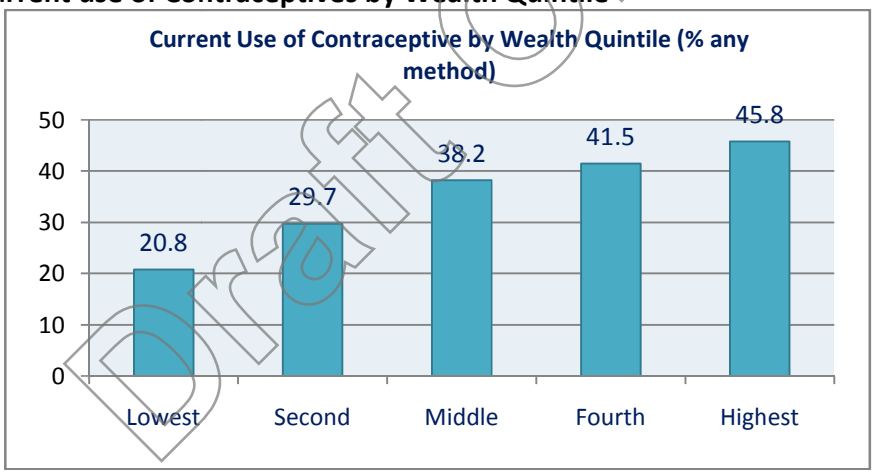
Figure 2.2: Unmet Need in Sindh



Source: PDHS 2012-13

Apart from issues related to quality and unmet need, the figure 2.3 provides more insight into how inequities prevail in terms of wealth quintiles in the country. The use of contraceptives is less in lowest quintile (20.8%).

Figure 2.3: Current use of Contraceptives by Wealth Quintile



PDHS, 2012-13

The above analysis suggestsa need for shift in fundamental approach on FP. In order to cater to un-met need it is imperative to have skilled human resources serving in rural and remote areas besides urban.

The LHWs and other outreach cadres based in rural and remote areas need to focus on quality FP services and counseling. It is critical to enhance their knowledge and skills. In this regard, UNFPA in collaboration with PWD and the DoH is providing training to LHWs and other cadre i.e. CMWs, FWW, LHVs on Healthy Timing and Spacing in Pregnancy (HTSP)[13]. Before focusing on skills of human resources

[13] Training of Trainers (ToT) on HTSP includes 3 days training while LHWs refresher will take 5 days. It is crucial to assess the impact of trainings, in this regard, a research has been conducted by an Islamabad based INGO

for addressing quality and equity issues there is need to assess the available human resources in health and population sectors.

2.3 Rights Based Approach in Family Planning

The rights based approach is mainstay of the Training Strategy. This approach is closely related to provision of quality services through skilled providers. One of the areas where women need FPRH services the most is during the episodes of "domestic violence" which is rampant in our society especially in rural, remote and poorest of the poor households[14]. The health and reproductive health providers are in best position to come into contact with women in their reproductive age when there are maximum chances of domestic violence. The National Standards for Family Planning has given emphasis on special needs of abused women. According to the Standards, "the most important contraceptive service for women in violent relationships is counseling, which must include recognition of the women's difficulties with her partner and help in choosing a method that will not make those difficulties worse"[15]. Moreover, the National Standards also outline the rights of FP clients. Those rights are provided in the box below:

RIGHTS BASED APPROACH

National Standards on FP has outlined following 10 Right Based Approaches regarding family planning:

Right to Information: right to know the benefits of FP for an individual and the family
Right to Access: to receive FP regardless of social status, economic situation, religion, political belief, ethnic origin, marital status, geographical location, or any other group identity
Right of Choice: to decide freely whether or not to practice FP
Right to Safety: protection against any possible negative effect of a FP method; effective contraception against any unwanted pregnancy; protection against possibility of acquiring infection
Right to Privacy: an environment in which she/he feels confident and relaxed during an environment
Right to Confidentiality: of information disclosed and service received
Right to Dignity: treated with courtesy, full respect regardless level of education and social status
Right to Comfort: related to adequacy and quality of services an environment keeping in view the cultural values, characteristics, and demands of the community
Right of Continuity: to receive contraceptive services and supplies as per needs
Right of Opinion: to express positive or negative views about the quality of service

(*Source: "Pakistan National Standards for Family Planning", published by FALAH Project for the (erstwhile) Ministry of Population Welfare, Islamabad; Fourth Edition, 2009, later on adopted by PWD, Sindh*)

[14] Human Rights Watch, 'Crime or Custom?Violence against Women in Pakistan, Report of Human Rights Watch 1999. [online][cited 2006 March]. Available from: URL: http://www.hrw.org/reports/1999/pakistan/index.htm
[15] Pakistan National Standards for Family Planning

The United Nations Population Fund (UNFPA) stresses the need for FP programming based on human rights, cultural sensitivities and gender responsiveness. "A practical implementation of human rights requires clear sense of interplay between gender, culture and human rights"[16]. The issue of gender equality and women empowerment is one of UNFPA core program areas[17]. Gender equality underlines ICPD goals and Goal No. 5 under SDGs.

Based on these core principles of any family planning program, the providers' training will include modules on rights based approach.

SECTION - 3 FAMILY PLANNING TRAINING IN PUBLIC & PRIVATE SECTORS: AN OVERVIEW

[16] UNFPA HR Based Approach in FP
[17] ibid

3.0 FP Trainings in Public Private Sectors: An Overview

3.1 Policy Planning Frameworks

3.1.1Policies, Plans and International Commitments

After the 18th Constitutional Amendment, population and health sectors are devolved to provinces. Consequently, provinces are not only responsible for formulation and implementation of policies and plans but also require contributing towards international commitments made by Pakistan. These commitments can be achieved when robust policies in terms of accessible, affordable and quality services with trained human resource are in place with proper implementation ensured.

Pakistan is a signatory to two major family planning related international commitmentsi.e. FP2020 and Sustainable Development Goals – former directly related to family planning, while the latter, contains at least one goal related to health and population issues. Earlier commitments were made at 1994 ICPD Conference and under MDGs.

3.1.2. FP2020

The commitments made by Pakistan under FP2020 London Summit are related to enhancing CPR; offering birth spacing services through public and private sectors; enhancing investment on FP; making contraceptives part of essential services package; strengthening supply chain management, trainings, communication; refocusing LHWs work on family planning as per their original mandate; and establishing public private partnerships. One of the pre-requisite for achieving FP2020 targets is skilled human resource available to provide family planning services at the health and population departments' outlets.

3.1.3Sustainable Development Goals (SDGs)

The Sustainable Development Goals have been set for the next 15 years by the world leaders gathered at UN. The 'good health and wellbeing' is 3rd goal out of 17 goals that envisages ensuring healthy lives and promoting well-being for all at all ages[18]. There are mainly 9 targets under the goal 3. The target No. 3.7 states: "by 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning information and education, and the integration of reproductive health into national strategies and programs." The target 3.c focuses more on capacity of human resource to deliver on SDGs - 3. It says "Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and Small Island developing States.

The logical response to FP2020 and SDGs is to have fully functional health and population systems with affordable and accessible services with higher level of quality in terms of services, supplies and human resource.

In case of Sindh province, certain policies and plans can be referred for assessing the level of preparedness and for achieving sectoral objectives. The draft Population Policy; Costed Implementation Plan (CIP); and Health Sector Strategy are worth mentioning here:

3.1.4ThePopulation Policy

The policy provides a comprehensive framework on human resource development. It comprises of trainings under two components i.e. technical & management. As per policy, the number of Regional Training Institutes will be increased along with curriculum and training methods improved.

The policy document also emphasizes capacity building for health sector i.e. contraceptive techniques; infection prevention; effective counseling; social mobilization. Besides, trainings for population and health sectors basic FP trainings will be organized for NGOs. Additionally, crash courses for health staff; NGOs; private hospitals; nursing homes; health points at industries and corporationswill be organized. The Population Welfare Training Institute (PWTI) will arrange the management trainings.[19]

3.1.5Health Sector Strategy for Sindh

The Health Sector Strategy for Sindh focuses on family planning in its section on "special areas of focus". The Strategy re-defines links with PWD by provision of FP services through district and urban primary healthcare. It also envisaged that the linkages will be created between FP and MNCH within health sector. The Strategy will focus on FP needs of young couples and integration of community based behavior change communication. The training on birth spacing for staff at all DoH facilities will be conducted.[20]

3.1.6Costed Implementation Plan (CIP) on FP, 2015-20[21]

In the context of FP2020, the Five Years Costed Implementation Plan (CIP) Sindh is now recognized as key strategic plan to implement strategies for achieving the commitments made at London Summit 2012.

[18] Sustainable Development Goals; https://sustainabledevelopment.un.org/sdgs (accessed on June 25, 2016)
[19] Population Welfare Department. Population Policy for Sindh, 2016
[20] Department of Health. The Health Sector Strategy 2012-20
[21] Costed Implementation Plan (CIP) for Sindh has been developed based on FP2020 commitments. The PWD has prepared the Plan in collaboration with DoH, PPHI, LHWs, MNCH, development partners, INGOs/NGOs. The Bill & Melinda Gates Foundation supported the development of the Plan while Pathfinder International provided the technical support (http://www.pwdsindh.gov.pk/Publications/e-books/discr.htm)

The CIP has been developed after wider consultations within public sector and with development partners and NGOs. The document is an approved strategy of the Government of Sindh on FP[22]. The objectives of the CIP include:

- Enhance CPR from 30% in 2015 to 45% by 2020
- Reduce unmet need for family planning from 21 percent in 2015 to 14 per cent by 2020
- Ensure contraceptive commodity security up to 80% for all public sector outlets by 2018

For achieving CPR of 45% (modern and traditional), an estimated 1.298 million MWRA will have to be reached by 2020 as "additional users". The CIP has six Strategic Areas for achieving the target of 45% of CPR by reaching to "additional users". The CIP gives special attention to ensure quality of services through enforcement of FP Standards and imparting training on an extensive scale. The six strategic areas are mentioned in the matrix (3.1).

Matrix 3.1: Six Strategic Areas of CIP Sindh 2015-20

CIP Strategic Areas	
1. Functional Integration	Functional integration for FP activities; Referrals by LHWs; LHWs focus on FP; incentives; Basic and comprehensive EmONC
2. Quality of Services	**Manual on FP Services enforced; trainings; youth friendly and client centered services; client satisfaction; RTIs, CME**
3. Supply Chain Management	Contraceptives made available at UC /facility level; timely procurement, forecasting, quantification; strengthening cLMIS; etc.
4. Expanding Services with Supply & Demand side intervention	6586 Community Based FP Worker s in rural, remote, urban slums in LHW uncovered areas; task shifting ; public private partnership ; vouchers for poorest of poor; CSR; Population Houses
5. Knowledge & meeting Demand	Better counseling; community awareness through selected CBOs and SukhiGharSalahkar/elders; IPC/mid media; life skills at colleges, universities; youth friendly spaces at universities
6. Performance Monitoring & Accountability	Baseline; Joint M&E and supportive supervision; use of smart phones, GIS; Mid Term assessment; Annual performance report; End of project evaluation ; policy, system strengthening; Social Sector forum; media forum ; reporting on Restraint of Child Marriage Act

Source: Population Welfare Department, Government of Sindh, Costed Implementation Plan on Family Planning for Sindh (2015–2020). Sindh, Pakistan: Population Welfare Department; December 2015

3.1.7 PC 1 on CIP

Apart from its routine population program, the Government of Sindh has allocated an amount of Rs. 890 million for the next four years for implementation of key interventions under the CIP Phase-I project. A PC 1 in this regard was approved and funds have been released for the last quarter of fiscal year 2015-16. The CIP Phase-I is being implemented in 10 districts of Sindh i.e. Mithi (Tharparkar); Thatta/Sijawal;

[22]Population Welfare Department, Government of Sindh, *Costed Implementation Plan on Family Planning For Sindh (2015-2020)*, Sindh, Pakistan: Population Welfare Department; December 2015www.pwdsindh.gov.pk

Badin; Gadap town; Kashmore; Hyderabad; Larkano; Sukkur; Noshehroferoze; and Dadu. The objectives of the program are: strengthening of existing service delivery; imparting of accelerated interventions; implementation of functional integration and referral networking; capacity building of service providers; and introduction of innovative/ proven practices.

The area No. 2 of CIP relates to ensuring quality services. Under this area trainings will be conducted on national standards manual; healthy timing & birth spacing (HTSP); LARCs; IUCD insertion and removal; improving skills of FWAs; LHWs; CMWs; PPIUD.

3.1.8Trainings identified under CIP and Manual of FP Standards

Under the CIP, the Strategic Area 2 takes into account the capacity development of human resource. In this regard, training needs (pre and in-service) have been identified under different categories for staffs working at PWD, DoH and other related programs (Matrix 3.2):

Matrix 3.2: Training needs identified under CIP

Training	Description	Nature of Training*
Training/orientation on FP Standards	ToT; districts and facility level; TNA	Pre & In Service
FP counseling, HTSP, youth, Post partem IUD; PPFP	-	In Service
LARC	4 days training for WMO at RTIs	In Service
Refresher for MSUs	6 days training	In Service
Client Centered Approach, prevention of infection	6 days to LHVs, CMWs	In Service
IUD insertion & removal by FWWs	6 days	In Service
ToT at RTIs and material	-	For Pre & In Service
2 new RTIs	Mirpurkhas and Benazirabad	For Pre & In Service
LHWs training on HTSP	2533 trainings	In Service
Refreshers for Management of LHWs Program	DHO, PPIU, FPO, DCs & coordinators	In Service
CMWs training	Counseling, service delivery/ youth	Pre & In Service
CMWs training	IUCD insertion	In service
CMWs training	PPIUD, post abortion FP	Pre & In Service
Contraceptive Logistic Management (cLMIS)	Refresher training	In Service
cLMIS	Forecasting and quantification	In Service

Source: Population Welfare Department, Government of Sindh, Costed Implementation Plan on Family Planning for Sindh (2015–2020). Sindh, Pakistan: Population Welfare Department; December 2015(column added later)*

Under the CIP, a renewed focus has been rendered to the "Manual of National Standards on Family Planning Services". The Manual was prepared nationally for the erstwhile Ministry of Population; later on it was adopted by the PWD, Sindh. The Manual provides standardization of services; methods; training of human resource; supervision, monitoring and evaluation. The Manual has identified trainings to be undertaken at RTIs and PWTIs (Matrix 3.3).

Matrix 3.3: Trainings specified in Manual of National Standards on Family Planning Services

Regional Training Institute	Population Welfare Training Institute
Advance training of FWWs	Programmatic
Refresher training for FWWs on RH/FP	For DPWOs, TPWOs, demographers etc.
Orientation Training for MO RHS A	Refreshers for various categories
Paramedics (LHVs, TBAs, midwives), NGOs	Non programmatic
Orientation for doctors from DoH, PWD, NGOs	Orientation for different departments, NGOs , CBOs
Training of university teachers, students	Specialized training for various categories
TOT on various techniques for non-program and program areas	

Source: National Manual on Family Planning Services

In conclusion, all the above policy instruments have emphasized on need for competent, skilled and trained human resource. A logical next step of those policy documents would have been a comprehensive Training Strategy. This Strategy caters to that felt need.

Different cadres related to family planning receive pre & in-service training based on set plans but there is lack of a comprehensive and systematic approach based on a Training Strategy that may achieve long term policy goals and career plans. There is need for trainings on set frequency, in integrated manner and based on sectoral objectives and standardized curriculum.

In this regard it is imperative to know the numbers, categories of providers from within public sector as well as private sector. Based on that assessment of number of trainees it would be evident whether Regional Training Institutes (RTIs) are sufficient in number? It is also required to know the training packages i.e. IUCD, Implanon, PPFP, management etc.; standardized training manuals for ToT; for trainees; and schedule for training (both for theory and practical classes). It will also be pertinent to know the number of the trainees; resource allocation from PWD, DoH, PPHI and NGOs as well pooling in resources. The pre-service training aspect has remained as an isolated aspect. Before addressing the bottlenecks in this area, a mapping exercise would be in order to know the institutes in public and private sector that provide FP trainings. The mapping would not only include training institutes but academic institutes like medical colleges, nursing and midwifery schools. Furthermore, the licensing bodies have a critical role to play in standardization of trainings, thus their role may be further reinforced. Globally evidence suggeststask shifting approach should be adopted to scale up FP services. In this regard, LHWs may be trained/allowed to provide first dose of injectable method of FP. CMWs and LHVs be trained/allowed to insert implanon; and staff of health facilities may work as counselors on FP.

3.2 Institutional Mechanisms

3.2.1Human resource in Population & Health Sectors

The Department of Health (DOH) and the Population Welfare Department (PWD) have a network of static and outreach services.

The facilities of PWD include Reproductive Health Services (RHS-A) Centers; Family Welfare Centers (FWCs); Mobile Service Units (MSU); RHS B Centers; Social Male Mobilizers; and No-Scalpel Vasectomy (NSV) centers[23]. For the purpose of capacity building, the PWD has four Regional Training Institutes (RTIs) which provide skill-based training in FP/RH for doctors, medical students, nurses, lady health visitors and other paramedics. The RTIs also arrange orientation sessions for awareness of hakims, homeopaths, community health workers, teachers and college students. There is one Population Welfare Training Center (PWTI) situated in the provincial capital. That provides trainings to non-program staffs.

The PWD has total staff strength of 10,597 across the province. That include staffs at head office; regional directorate; Population Welfare Training Institute; RTIs; District offices; Taluka offices; FWCs; MSUs, RHS; MPSBs; and social mobilizers. At the PWTI there are 06 faculty members along with 14 other staff. PWTI can adjust three batches each consisting of 30 trainees (Annexure I).

3.2.2Communication, Training, Logistic and Supplies Wing, PWD

At the time of erstwhile Federal Ministry of Population Welfare, the trainings were managed through Directorate of Clinical Training. The Directorate was responsible for human resource development; development of uniform curricula, training material, conduction of examination for certification, assessment of trainings for ensuring quality[24]. In the wake of devolution, the PWD is now responsible for organization and management of trainings.

In this regard, the Communication, Training, Logistic and Supplies Wing at the PWD is responsible for the management of trainings. This Wing is headed by an Additional Secretary (BPS 19). The Wing is responsible for four vital functions in the Department i.e. communication, training, logistics and supplies. This also indicates the need to assess that how the Wing is managing to handle four different functions and how it can be strengthened further.Following are functions of the Wing[25]:

a) To guide and monitor District / Tehsil/ Towns levels IEC and advocacy activities.
b) To plan and monitor Social Mobilization activities at FWC, MSU and RHS-A Service Centers levels.
c) To develop IEC materials to be used in the field.
d) To carryout local non-clinical training activities and coordinate in this respect with the Directorate of Program Training and Population Welfare Training Institute (PWTI), NIM, PIM, NIPS, Pop Council and other Government and non-government training Institutes.
e) To process the applications from candidates for in-country and foreign trainingopportunities.

[23]Population Welfare Department: Population Welfare Program Sindh PC 1, Five Year Plan (2010-15), Sindh, Karachi
[24]UNFPA.Contech International. Part I, FP In Service Training Mechanisms and Capacity, February 2013
[25]Website of Population Welfare Department, Sindh
http://www.pwdsindh.gov.pk/Functions/Provincial%20Admin.htm#4. Functions Of Communication, Training, Logistic and Supplies Wing

f) To manage and monitor the logistics work of the province and to ensure proper maintenance of transport fleet in the field.
g) To manage coordinate and monitor the supply of medicines, equipment, furniture, fixture, contraceptive etc., in the province.
h) To provide logistics support.

It is imperative to assess the Communication, Training, Logistic and Supplies Wing in the context of its effectiveness in managing, monitoring and evaluating trainings. There is need to strengthen further the Wing. Since the Medical Wing in the Department also assesses the training plans hence, closer cooperation between these two wings would be useful.

3.2.3 Human Resource at Department of Health

The Department of Health currently employs 21,042 doctors/specialists; 2,628 nurses; 894 LHVs; 40,000 paramedics; 1705 CMWs; 22,575 LHWs and 770 Lady Health Supervisors.Besides, a vast network of primary, secondary and tertiary facilities; the DoH has a Health Development Center (PHDC) at Jamshoro and District Health Development Centers (DHDC) at several district headquarters. These PHDC and DHDCs are mandated to provide training to doctors and paramedics. There are 44 schools of public health (Annexure II).

According to "Human Resource for Health Strategy of DoH", there are 1,771 health facilities in the province which have 6,633 sanctioned positions (67% filled) of general doctors and dentists (grade 17-20). There are 883 posts of specialist cadre(31% filled); 2,711 sanctioned posts of nursing (76% filled); 5,385 paramedics sanctioned posts (95%) filled[26].

Provincial Health and Development Center (PHDC), DoH is responsible for research and trainings in health sector. The Training Plan is being prepared based on Need Assessment. Based on the Plan and available budget, the categories of trainees are identified and a year wise calendar is prepared. The PHDC has sufficient staff but that requires refreshers. The equipment and large rooms are available; however, hostel needs to be refurnished/renovated. One of the reasons for shortage of some facilities is limited budget available for PHDC.

The Department of Health has outsourced several primary and secondary level care facilities in the province to NGOs.It would be pertinent to engage these NGOs in terms of family planning related training.

3.2.4Stakeholders in Family Planning

The Development partners are supporting FP initiatives in the province through selected INGOS, and NGOs. Some of the key INGOs/NGOs providing FP services include Jhpiego/MCHIP; Greenstar Social Marketing; Mariestopes Society; Aman Foundation/Sukh Initiative; Family Planning Association of Pakistan (Rahnuma FPAP); Indus Hospital; HANDS; Merlin; IHS; Aman Foundation and others.

[26] Strategy on Human Resource for Health, HSRU, Department of Health, Sindh through technical support and facilitation of WHO

These stakeholders do undertake various trainings to ensure quality services. The strategy has taken into account the role of these stakeholders. The matrix 4 provides a list of stakeholders:

Matrix 3.4: Stakeholders regarding Family Planning in Sindh

No.	Stakeholder	Implementing Partner
Public Sector		
1	Population Welfare Department	
2	Department of Health	
3	PPHI	
4	LHWS Program	
5	MNCH Program	
Development Partners		
1	UNFPA	
2	USAID	MSS, MCHIP, JHCC, DELIVER, HSS
3	Bill & Melinda Gates Foundation	Pathfinder International
4	The David & Lucile Packard Foundation	DKT International
5	Packard Foundation	Aman Healthcare
6	UNFPA	PWD, MSS
7	International Planned Parenthood Federation (IPPF)	Rahnuma-FAMILY PLANNING ASSOCIATION OF PAKISTAN

3.2.5 Training Institutes in Sindh

There are seven different categories of training institutes in Population and health sectors. These are responsible for catering to the FP related trainings (clinical and non-clinical) in public and private/NGO sector. The institutes include:

- Population Welfare Training Institutes (PWTI)
- Regional Training Institutes (RTIs)
- RHS Master Training Centers
- Provincial Health Development Center (PHDC)
- District Health Development Center (DHDC)
- Nursing School
- Public Health Schools

Following is functioning of each institute:

3.2.5.1 Population Welfare Training Institute (PWTI)

Population Welfare Training Institutes provide non-clinical and management related trainings for program and non-program staff. Pre service training for new staffs and refresher trainings are organized for the staff of PWD, faculty members of PWTIs, RTIs; and staff at district and taluka levels. Likewise for

non-program staff, orientation sessions for planning staff, administrators, midlevel managers from Departments of Health, education, agriculture, social welfare, local government, women development, students of universities, print and electronic media; NGOs, lawyers, elected representatives, general practitioners etc.

PWD has one Population Welfare Training Institute (PWTI) at Karachi that imparts following trainings:

Table 3.5 Trainings Arranged by PWTI, Karachi

S.No.	Training Name	Category	Duration
1.	Pre-Service Training	FWW's (BPS-08)	6 days
2.	Initial Service Training For FWA's	FWA's (Male/Female) (BPS-5-08)	6-days
3.	Office Management	Steno typist / Stenographer / Assistant (BPS-14-16)	6 days
4.	Financial Management	Officers (BPS-17 , 18 & 19)	6 days
5.	Financial Management	Medical Officers (BPS-17)	6 days
6.	Teaching Techniques	Dy. DDPWOs (BPS-17-18)	6 days
7.	Office Management	LDC / UDC/ Library Assistant	6 days
8.	Training of Demographers	Demographers, Statistical Assistants	6 days
9.	Teaching Techniques	Faculty Members of RTIs	6 days
10	Planning Officers	D.S /S.O (BPS -17-18)	6 days
11.	Research Methodology	Statistical Assistants (BPS-11)	6 days
12.	Record Keeping and ELMIS	Store Keepers (BPS-5-08)	6-days
13.	Safe Driving	Drivers (PS-04 -08)	6 days
14.	How to Serve Guests in Office	Peons &Chowkidars (BPS-02-04)	6 days
15.	Investing in Young People	Students from the Universities of Sindh Province (Non-Program Personnel)	01 day
16.	Islam and Family Planning	Religious Leaders	01 day

Table 3.6 Refresher Trainings (2013) Non-Technical arranged by PWTIs Training Institute

S.#	Training Name	Category	Total Trained	Participants Group	Duration
1.	FP-Counseling, Technical Capacities, Communication, Monitoring, Demographic etc.	FWW	128	25-30	6 days

2.	FP-Counseling, Technical Capacities Communication, Monitoring, Demographic etc.	FWA's (Male)	60	25-30	6 days
3.	FP-Counseling, Communication, Monitoring, Demographic etc.	FWA's (Female)	61	25-30	6 days

3.2.5.2 Regional Training Institute

The PWD has four Regional Training Institutes at Karachi, Hyderabad, Sukkur andLarkana. The Regional Training Institutes provide trainings in reproductive health & family planning to doctors, medical students, nurses, student nurses, LHVs, and paramedics. Besides, Hakeems, homeopaths, community health workers associated with NGOs, teachers, college students are provided with awareness and orientation sessions.

Table 3.7 Regional Training Institute in Sindh

S.#	Location of RTIs	Total
1.	Karachi	01
2.	Hyderabad	01
3.	Sukkur	01
4.	Larkana	01

The RTIs provide both pre and in-service trainings. It offers 24 months basic pre service training for FWWs; 3 months advanced training for FWWs to become FW Counselors; 6 months advanced training for FW Counselors to become FTOs; and 5 months training of FW Counselors to become ASTs. These also offer 3 months pre-service training for FWAs on RH & FP. The USAID is supporting to rebuild two existing RTIs at Larkano and Sukkur. Once these are built, a state-of-art training infrastructure would be available in these regions.

Table 3.8 **Training arranged by RTIs**

S.#	Training Name	Category	Duration
1.	Training on Implanon and Jedelle Insertion and Removal	Medical Officer, PWDS, PPHI, MNCH, Green Star, Marie Stopes, DKT etc.	4 days
2.	FP Counseling and Technical Capacities	Medical Officers, FWWs, CMW, LHVs PWDS, PPHI, MNCH and other NGOs	6-days
3.	IUCD Insertion and Removal	Medical Officers FWWs, CMW, LHVs PWDS, PPHI, MNCH and other NGOs	6 days
	Comprehensive Competency Family Planning	FWWs, CMW, LHVs PWDS, PPHI, MNCH and other NGOs	6 days

3.2.5.3 Reproductive Health Services –A (RHS A) Center

RHS A Centers at the teaching hospitals with contraceptive surgeries provision are declared as RHS Training Centers. These centers provide basic and refreshers for program and non-program medical doctors in surgical methods, counseling, IPC, implant insertion/removal techniques; trainings for paramedics in operation theater management, infection prevention; FP awareness sessions at educational institutions; on job supervision and monitoring.

Table 3.9 Trainings arranged by RHS-A Centers

S.#	Training Name	Category	Duration
1.	Practical Training on Implanon and Jaddelle Insertion and Removal	Medical Officer, PWDS, PPHI, MNCH, Green Star, Marie Stopes, DKT etc.	1-2 days
2.	Minilaptromy and Tubal ligation training	Medical Officers,FWWs, CMW, LHVs PWDS, PPHI, MNCH and other NGOs	28 days

3.2.5.4 Provincial Health Development Center (PHDC)

Established under the Department of Health, Sindh, the Provincial Health Development Center (PHDC) is located in Jamshoro and works under the administrative control of DG Health Services, Department of Health. The PHDC provides technical support to health services and providers through continued educational, developmental and research activities[27]. Apparently, the objectives of the PHDC do not include FP related trainings to service providers in the Health Department.
In the post devolution scenario, PHDC needs to be rejuvenated and transformed into a "Provincial Health Services Academy (PHSA)" on the pattern of Health Services Academy.

PHDC provides human resource development and research support to the health sector in the province. It also provides support to District Health Development Centers (DHDCs).

PHDC focuses on four aspects of human resource development:

- Induction trainings for officers
- Promotion of medical doctors (mandatory training)
- Training for placement (mandatory) based on management courses
- Training of DHDC master trainers

However, these functions are marred by lack of appropriate funding.

3.2.5.5 Public Health Schools

[27] UNFPA, Contech International, Part I – FP In-Service Training Mechanisms and Capacity, February 2013

Public health schools provide pre-service training for Lady Health Visitors and Community Midwives. There are components on family planning in the training modules of these workers. However, there is need to have separate modules on different aspects and methods of family planning.

3.2.5.6 Nursing Schools

The Nursing schools cater to the training needs for general nurses. These schools impart pre-service trainings. Usually nursing cadre does not provide family planning services however; it must be added as one of their core functions.

According to the Assessment conducted by UNFPA/Contech International, "exclusive training on family planning is not implemented in DoH administered institutes"[28].

3.2.5.7Trainings by Non-Governmental Organizations

The private sector INGOs/NGOs are playing significant role in imparting FP services. There are different modes of training being provided to service providers working with those organizations. Following matrix provides information on some of the key aspects of FP related work and capacity building related to FP:

Matrix3.5: FP Trainings by key INGO/NGOs Partners in FP

Service Delivery Mode	Categories and number of HR	Mode of Training	Training Plan
Greenstar Social Marketing			
Operations (clinics etc.), health services; IPC; helpline; Training supportive supervision; refreshers; On job training; Implanon training at PWD;	Rural Clinics: 95; Signature Clinics 01; MIO training 45; PBCC training 01; Chemist Venture 01; SundarSitara Voucher 100 Training staff: 38 Network staff: 125 IPC: 600	Class room training On job Refresher Head of Training Master Trainer Clinical Trainer	Implanon refresher; PPIUD; MVA refresher
Jhpiego/MCHIP			
MCH Centers (out of 7	FWCs 960; Doctors/	Induction training	Plan available

[28] ibid

service components one is FP); routine FP; PPFP (IUD); Implanon; Sukh counseling facilities (Korangi, Landhi, Bin Qasim) - FWC and MCH centers; BHUs, RHCs	WMO/ LHVs - 1200;	In service (through monthly visits for supportive supervision and need based refreshers)	PPHI doctors trained 600; Sukhperi urban (FWC 40, MCH 40 - 21 trained); 1200 doctors, CMW, LHVs trained; VCAT: to be trained 135 (trained 37) Comp. FP: to be trained 30 (trained ..) Service providers on FP and quality: to be trained 180 (trained ..) ; management of abortion and counseling: to be trained 40 (trained ..); refresher for health providers planned for 60; supportive supervision for mid-level managers of DoH, PWD planned for 20; IP (PWD 24, MCH 11); FP (PWD 33, MCH 28); VCAT facility staff (PWD 19, MCH 18, Sukh 95); Tele health (Sukh 16); Refresher ATH (Sukh 9)
Mariestopes Society			
Social Franchise; Outreach; Mobile Unit; Helpline (08002233); IPC through FHEs; Mid-level provide IUD and short term; doctor provide TL, Implenon; Trained from PWD; Supportive supervision MSI checklist;	Mid-level paramedic and LHVs: 250 Doctors 50 Outreach: 4+28 Outreach Mobile Unit:2 paramedics	Refresher: once a year Implanon/TL: at PWD FP counseling: MSS with JHU for ToT	There is Annual Training Plan, a quarterly plan is prepared based on Annual plan

Rahnuma-Family Planning Association of Pakistan (Sindh Region)			
Functioning Family Health Hospitals (2). Functioning Family Health Clinics (19) Services; FP, SRH, Prenatal, Natal, postnatal, Safe Abortion, TIA Non-SRH General Health. Outreach; Mobile Services Unit (1). Helpline (0800-44488);	FHH Khi HR; 29 FHH Badin HR; 26 FHCs HR; 37 MSU HR; 3	On Job training. Refresher Training. TOTs. Clinical Trainings with Practical Exercises.	PPIUCD IUD Insertion & Removal. Implant Insertion & Removal. Refresher of MVA Services.
National Committee on Maternal, Neonatal, Child Health (NCMNCH)			
Planned trainings by NCMNCH			
Nil	120 Midwifery tutors of 60 schools of Sindh both from public and private sector. *These tutors are teaching family planning to: Nurse midwives Community midwives Lady Health Visitors	• Adult teaching learning methods • Participatory learning • Group work • Role plays • Demonstration and return demonstration • Guided imagery • All participants provided printed material specially developed on family planning • Follow up (to observe teachers in action)	Six workshops for 20 participants each to be held at Karachi, Hyderabad and Sukkur. 1).23-25August 2016 at Karachi 2)6-8 September at Hyderabad 3)28-30 September at Karachi 4)17-18 Oct at Karachi 5)26-28 Oct at Karachi 6)3rd week of Nov 2016 at Sukkur

Training being carried out currently by NCMNCH			
Service Delivery Mode	**Categories and number of HR**	**Mode of Training**	**Training Plan**
Promoting Institutionalization of Post-Placental and Immediate Postpartum Insertion of Intrauterine Contraceptive Device (PPIUCD)	To build capacity of 802 Skilled Birth Attendants (SBAs), i.e. Doctors, practicing Lady Health Visitors (LHVs), and Midwives at the intervention sites on PPIUCD counseling and insertions during period March 2016-Feb 2019 in Karachi, Lahore and Rawalpindi/Islamabad	Competency based 2 days Classroom training and 3 days Clinical training Methodology: Classroom training: Presentations, discussions, group work, role plays and demonstration on models Clinical training: Satisfactory performance of PPIUCD counseling and insertion skills on clients as per checklist • All participants are provided printed material specially developed on postpartum family planning	A total of 802 new SBAs will be trained: Sindh- 173 Punjab- 629
Training held in the previous phase in Sindh			
Training for and Institutionalization of Post-Placental and Immediate Postpartum Insertion of Intrauterine Contraceptive Device (PPIUCD)	694 SBAs i.e. Doctors, practicing Lady Health Visitors (LHVs), and Midwives were trained at the intervention sites in Karachi (Sindh) on PPIUCD counseling and insertions during February 2012–February, 2016	Competency based 2 days Classroom training and 3 days Clinical training	A total of 694 SBAs were trained in Karachi (Sindh): February 2012 – September 2013- 182 October 2013 – February 2016- 512
Midwifery Association of Pakistan			
	Midwives	FP Training for the last 3 years	3 Trainings conducted on the eve of International Day of Midwives

In conclusion, the public sector has well established training mechanisms however, with the increase in the volume of human resource there is certainly need for enhancing capacity to absorb more trainees; more clinical sites for hands on practice. These institutions ought to adapt to modern technologies and methods besides, creating linkages to regulatory bodies like Nursing Council, PMDC; HEC etc. Moreover, creation of a Sindh Nursing Council may also be assessed in the wake of devolution.

3.3 Curriculum &Trainings

The PWTI and RTIs have developed curriculum regarding pre and in-service trainings. The curriculum includes various categories i.e. trainers guide; manual of standards; reference manual; learners guide and other text books.

As per information gathered from PWD, the curriculum for various cadres' training is based on National Standards on FP. The updates related to any new method/technique are provided through an official letter from the Department. For example, letters on implanon insertion and removal, WHO criteria for 2016 are being followed.

There is need to develop curricula for some categories of staff of DoH. For example, LHWs require updated curricula that would also be adequate to cater to their practical needs. One of the missing areas in LHWs course is referral of FP/MCH cases. There should be at least one month dedicated theoretical training on counseling, communication/IPC, referral, contraception etc. It is also noteworthy that the Medical doctor who imparts training to LHWs has himself/herself limited knowledge on family planning. Therefore, alternatively, RHS A doctor can train LHWs.

Moreover, one month (1 month) pre-service training is required for CMWs, LHVs, and Nurses. Besides, there are negligible FP related training opportunities for MOs/WMOs during their pre- service training. There is only one chapter in the text book in the medical education that is covered under the training on Gynecology and Obstetrics and contains enough material for just one lecture. With a view to address this issue, some of the universities/medical colleges arrange special sessions for their students before allowing them to sit in the final exam. The Aga Khan University and College of Physicians and Surgeons of Pakistan sends its medical students to RHS teaching Center at JPMC Karachi for 15 days before appearing in the exam as a mandatory requirement.

The PWD training staff visits to Dow University of Health Sciences and the Liaquat University of Medical and Health Sciences for lectures on family planning. However, there is need to assess these approaches from the perspective of their usefulness and sustainability.

There is a disjoint between pre and in service training. Pre service training is more focused on theory with little emphasis on practical aspect. The course contents are usually not being updated to incorporate new information and knowledge and modern approaches. There are issues related to availability of adequate faculty, equipment, supplies necessary for smooth training. It is important to assess the capacities of those staff at various institutes and review the contents of text books.

Matrix 3.6: Pre-Service Training Material

S.No	Curriculum	Trainers Guide	Reference Manual	Learners Guide

1	MSU: Curriculum (Urdu)	Trainers Guide for MSU		
2	Curriculum for Social Mobilizers Male (Urdu	Curriculum for Trainers		
3		Curriculum for Trainers of Village Based FPWs (Male		
4		Trainers Guide for Pre Service Training of FWAs		
5	Training Curriculum for RH Services Package			
6	Curriculum for Female Family Welfare Assistants			
7		Facilitator Guide for Training Skills for Health Care Providers (Jhpiego)		
8			Reference Manual for Providing Contraceptive Implants (Jhpiego)	Course Handbook for learners Providing Contraceptive Implant (Jhpiego)
9	Notebook for Learners Providing Postpartum IUCD Clinical Services (Jhpiego)	Notebook for Trainers Providing Postpartum IUCD Clinical Services (Jhpiego)	Reference Manual Providing Postpartum IUCD Clinical Services (Jhpiego, Packard)	
10		Reference Manual Training Skills for Healthcare Providers 3rd Edition (Jhpiego)		
11	Resource Material for FWW 24 months Basic Training Course Volume III, PWD			
12	Resource Material for FWW 24 months Basic Training Course Volume II, PWD			
13	Client Centered FP Services (Basic) Participants Manual (Jhpiego, Pop Council)	Client Centered FP Services (Advanced) Trainers Manual		

Matrix 3.7: In-Service Curricula

S.No	Curriculum	Trainers Guide	Reference Manual	Manual on Standards
1		Trainers Manual FP Counseling (Tama, PWD)		
2		Trainers Manual for Mid-Level Service Providers for Post Abortion FP (Pathfinder)		
3		Trainers Guide National Standards for FP Services, Tama		Manual of National Standards on FP Services (2010) Pop Council, Jhpiego, Falah, MoPW approved
4	Participants Manual, Competency Based Clinical Skills for IUCD (Jhpiego, Pop Council) (Urdu, English)	Trainers Notebook, Competency Based Clinical Skills for IUCD	Reference Manual Competency Based Clinical Skills for IUCD (Jhpiego, Pop Council) (Urdu,	
5	FP Handbook for Service Providers			

During the process of curriculum development, many a times support from development partners is sought. For example Jhpiego, FALAH, Pathfinder and Population Council are some of the partner that have developed various material for trainings both pre and in-service. There is a need to see whether these training material were guided by National Standards of Family Planning, if not, then it should be ensured that the partners follow those Standards while developing training material. It is worth mentioning that there is little emphasis on modules on working with communities. The social male mobilizers, FWA (male and female), LHWs, CMWs and other relevant staff need to be trained on such modules. In this regard, modules have already been developed.

There is need for closer coordination between different training institutes to develop modules and training schedules as per need of the staff and that these do not overlap.This would require a careful review of curricula for different categories of health/RH providers.

In conclusion, the curriculum across the stakeholders (public and private) is not standardized and uniform rather these are tailor made as per individual stakeholder needs or as per the need of a project. The medical curriculum has negligible aspects on family planning. In this regard, Higher Education

Commission have vital role to play for the revision of medical curricula for addition of sufficient sections on family planning. Another aspect would be to make a shift from routine learning process towards the internationally acclaimed system of "credit hours". It will make it easier to compare the trainings between various institutions i.e. public and private and even international institutes. Moreover, there is need for emphasis on the areas like working with communities and modules on record keeping of supplies.

Furthermore, the principles of Adults Learning Theory should be followed. This is so that participants will learn more and reach their objectives better. For example, the sessions are designed so that lectures are very short and infrequent. There is a lot of variety in presentation media and activities. Communication is not only two-way but also multi-directional. The participants are experienced adult professionals. Their knowledge will be shared with their colleagues, and with the facilitators. "Trainer Talk" should be limited to a maximum of 50% in any session. This means that facilitators do less than half of the talking, and participants are very busy in large **group discussion**, **small group work**, **individual exerciseor study, learning by doing** (use of computer software), Case studies and Problem solving methodology needs to be introduced and followed. For facilitators who are used to lecturing, this will represent a major change.

3.4 Faculty/Trainers

The training institutes have technical as well as management staff positions. The PWTI is led by principal along with senior instructors and instructors. RTIs are headed by principal along with instructors. RHS Center are headed by Chief Medical Officer (CMO) who undertakes trainings as well as contributes towards planning for training. PHDC under the Department of Health is manned with a Project Director along with deputy directors and course directors.

The PWTI has sanctioned staff posted. The institute arranges a range of trainings covering the areas of RH/FP, safe motherhood, basic demography, service delivery requirements in compliance with job descriptions, financial and office management, communication, M&E. In order to fulfill these training needs, PWTI is allowed to hire external resource persons as well[29].

At the RTI, office of the principal is responsible mainly for the management; overseeing the training plans; coordinating with the Department. The Deputy Principal has more technical role i.e. development of training material; ensuring training quality; imparting trainings.

The RHS Master Training Centers conduct practical training, Mini-lap and bilateral tubal ligation trainings. A senior medical officer and a medical officer implement the training besides routine clinical work.

PHDC has staff strength of 10, comprising one Project Director, three deputy directors, three course directors and three instructors.

In conclusion, the training institutes face two challenges; one, some institutions have shortage of trainers; two, the plans for continuous enhancement of skills of faculty are rarely prepared that points towards shortage of funds and lack of expertise. There has been felt need for more staff keeping in view the volume of pre and in-service trainees. There have been budget constraints as well as restrictions on

[29]UNFPA. Assessment of Family Planning In-Service Training Mechanism & Capacity, Contech International, February 2013

new recruitments resulting into less sanctioned positions, while several positions at some institutions are lying vacant. RTIs face difficulty since no laid down procedures are in place for hiring of visiting faculty. An induction plan and follow up refreshers for the faculty need to be focused.

3.5Public Private Partnerships

Family planning services can be provided on wider scale in partnership between public and private sectors. As evidence suggests, 54% of the FP provision is through private sector. Therefore, the fundamental premise of FP services i.e. quality, equity, and right based approach and unmet need cannot be ensureduntil private sector is fully brought into mainstream of family planning provision. It is also the responsibility of private sector, INGOs, NGOs supported through development partners that they bring in initiatives to support public policy objectives.

The private sector entails broader layers of stakeholders like private sector universities, education institutions; private service providers i.e. general practitioners etc. In general terms, NGOs are also categorized under the umbrella of private sector, though mostly are not for profit. There are certain regulatory bodies like Nursing Council; Pakistan Medical & Dental Council (PMDC); Higher Education Commission that regulate the population and health sector institutions. Several professional associations also organize providers and motivate them to follow code of conduct and protocols in provision of services.

The partnership for FP could be strengthened once some of the bottlenecks are addressed.
The main concerns in this regard are that there is no uniform curriculum for trainings; INGOs, NGOs do provide trainings mostly based on their projects that are short-lived; and trainings organized by the development partners within country and abroad are seldom based on need assessment or reflected into departmental Annual Plans. Such trainings have no set followup mechanisms. The trainings provided by INGOs/NGOs have already been mentioned (Matrix 3.5)

Despite the fact that the development sector's trainings are conducted in isolation; confined to project areas and under a curriculum not in line with curriculum developed under training institutes of public sector, yet they have the potential to further enrich public sector training processes i.e. developingtraining tools, modules based on international best practices; supporting in Training Need Assessments; developing monitoring and evaluation mechanisms and quality assurance. Thus there are several windows of opportunities where public and private sector can work together on capacity development. These areas include uniform curriculum development on standardized pattern; knowledge management through information technology (IT); accreditation of trainings by PWD; joint forum to implement the standardized curriculum and the trainings.

3.6 Monitoring, evaluation, supportive supervision of Trainings and Training Need Assessment

Assessment of quality and effectiveness of trainings; supportive supervision of trained staff; and above all Training Need Assessment (TNA) pertaining to pre & in-service trainings are crucial areas. A systematic approach is required to keep these aspects upfront at the training institutes.

Although, there is practice of taking pre and post-tests to evaluate the quality of trainings by the faculty however, this practice is conducted on ad-hoc basis.Supportive supervision is a weak area. The supervisors also need further enhancement of technical competencies and skill. All supervisors must be trained and equipped with necessary tools and linked with district management to build staff skills and competencies.

Since trained staff mainly provides services at facility level, hence, their performance is closely associated with capacity of district management in terms of need for supervision of trained staff. District management requires more skills, resources and technical assistance to review the performance of trained staff at facility level. There is need for strengthening management training including planning, monitoring and supportive supervision.

Furthermore, the Training Need Assessment (TNA) is a useful tool to identify strengths of human resource andgaps to be addressed through appropriate trainings. The TNA also provides baseline against which progress can be measured[30]. Four elements are critical for successful training initiatives i.e. financial resources which are available regularly; skilled human resource for trainings that is well deployed and adequate in number; trainingvenues with adequate material, supplies and equipment; tools like standards, guidelines, curricula, job descriptions and training plans[31].

A well designed monitoring and evaluation system for trainings is needed. It also needs to provide space for research activities at PWTI, RTIs, PHDC and other institutions. Trainings may be linked to credit hours.

The Provincial Training Coordination Committee (PTCC) guides FP trainings both program and non-program including clinical and non-clinical. The Committee is chaired by Secretary PWD with Additional Secretary, all principals of training institutes, representatives of NGOs and development partners. This committee requires to be made more functional for overall guidance, review of monitoring and supervision initiatives. PTCC may also share its reports with Sindh FP2020 Working Group that is mandated for providing overall leadership and stewardship to take forward the agenda of FP2020.

[30] ACQUIRE Project/EngenderHealth;" Programming for Training Resource Package" https://www.engenderhealth.org/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2_resources/programming_for_training.pdf (accessed on June 25, 2016)
[31] ibid

SECTION - 4 WAY FORWARD BASED ON STRENGTHS, OPPOTUNIES & CHALLENGES

4.0 WAY FORWARD BASED ON STRENGTHS, OPPOTUNIES & CHALLENGES

There are certain strengths, opportunities and challenges that have implications for training initiatives. Before developing a way forward it is pertinent to briefly go through the main strengths, opportunities and challenges.

4.1STRENGTHS

Despite the fact that there are lots of challenges and issues related to family planning training still there are many strengths in the Departments of Health and Population on which future training approach may be developed. These strengths are mentioned as under"

The Department of Population Welfare has strong institutional mechanisms for training. For example, PWTI under PWD is an important institute that not only caters to the needs of PWD but other relevant departments and organizations. Four RTIs in different parts of the province are strength of the Department through these institutes, capacity of the staff at the Department as well as DoH and NGOs staff is developed. DoH has PHDC as its prime institute for training of medical officers and other staff. Many districts have DHDCs that provide trainings at districts level. Other positive aspects are functioning Public Health Schools, Nursing Schools etc.

From financing perspective, the Sindh government has allocated and released funding for PC 1 of CIP Sindh Phase I. Even before that, the government allocated funds for the procurement of contraceptives which means Sindh has started investing in family planning.

4.2OPPORTUNITIES

In post devolution period, several new steps and initiatives have been taking place which present promising opportunities for effective training plans. For example, draft Population Policy; CostedImplementation Plan (CIP) and already adopted Manual of FP Standards are some of the leading documents now available to the province. The development partners have moved to provinces in the wake of devolution. In this regard, USAID is supporting the Sindh in health and population sectors. Besides that UNFPA, Aman Foundation and Gates Foundation have been closely working with PWD and DOH. USAID is rebuilding two RTIs at Larkano and Sukkur. These opportunities provide a window for various initiatives on population sector that includes capacity development.

4.3 CHALLENGES

It has been noted over the period that the access and utilization of FP services needs further improvement. More importantly, availability of method mix and enhanced skills are required along with counseling capacities. There is need for 'training/capacity building reforms' in the public and private sectors.

Some of the fundamental concerns related to trainings are that

- Trainings are being conducted mostly in vertical manner without integrating them into horizontal manner linkages between pre & in-service trainings; coordination between different stakeholders
- Trainings lack keeping pace with recent developments and modern techniques in a systematic way.
- There seems a disjoint between pre and in-service training

Keeping these concerns in view, there has been need for a comprehensive Training Strategy for Sindh. In the absence of a Strategy it has been difficult for the public sector to negotiate for technical assistance from development partners for trainings in the wake of already limited technical and financial resources. There is also a need to create linkages with development partners and private sector in order to harmonize trainings being undertaken.

While preparing the Strategy, we need to keep it up-front that how trainings can be de-centralized. For example, in case of FWAs in rural areas, they are not used to leave their homes and stay out station for trainings. Thus, trainings need to be culturally sensitive.

There has been lack of strong linkages between private sector specifically INGOs/NGOs and the public sector in terms of strengthening capacity building initiatives. There are certain barriers like lack of a uniform curriculum; training guidelines/manuals; accreditation process. There is need to draw such uniform protocols from available documents like Manual of FP Standards.

Due to lack of avenues for practical training available to NGOs, the trainings are provided on dummies. Moreover, the FP providers and master trainers data base is required so that training plans would be updated from time to time based on available database. This will facilitate avoiding repetition in trainings. There are certain trainings that require to be conducted jointly by PWD and DoH i.e. PPFP.

There is need for a forum to discuss each training and its scope i.e. Tubal Ligation, LARC, short term etc. Such matters can be better addressed through joint mechanisms. In this regard, role of Provincial Training Coordination Committee and Sindh FP2020 Working Group is vital.

4.1 WAY FORWARD: A PARADIGM SHIFT

A paradigmshift is required in traditional training activities. A fundamental concern is that the trainings take place on ad-hoc basis as per financing available. The trainings take place in vertical manner (as standalone activity taken up in isolation from other stakeholders) which are usually not integrated within the system in horizontal manner. Besides, training is thought to be source of just

information;usually it is not utilized as source of enhancing skills. Apart from it, most of the training plans are prepared through 'top down approach' instead of 'bottom up approach'.

It is also important to link trainings with availability of services, equipment, supplies.Role of academic institutions and professional organizationscannot be under estimated in terms of trainings.The future trainings would be linked with reward and incentives for best performance. The approaches like E – learning and distant learning will be integrated into overall training plan.

It is pertinent to conduct an assessment of previous trainings to see the impact and also build robust follow-up mechanisms to monitor post training activities. . Such activity will allow to see the gaps and to conduct TNA. This will also indicate gaps regarding public and private collaboration.

The public sector programs need an in-depth analysis so that training needs are specified on strategic basis. For example, LHWs require refreshers on counseling skills; HTSP; management of side effects; referrals. Likewise, CMWs require the same trainings; in addition to that, CMWs require training in IUD insertion and management of side effects; implanon/jaddele insertion and Postpartum IUD and PAC-FP.It should be ensured that the training plans following Need Assessment to be carried out on period basis.This will ensure that trainings respond to the felt need of the population and health staff.

The trainings also need to be planned in close consultation with DPWOs. For example they can better inform that trainings for rural workers should be arranged in respective areas with proper incentives/allowance. This requires enhanced capacity of RTIs.

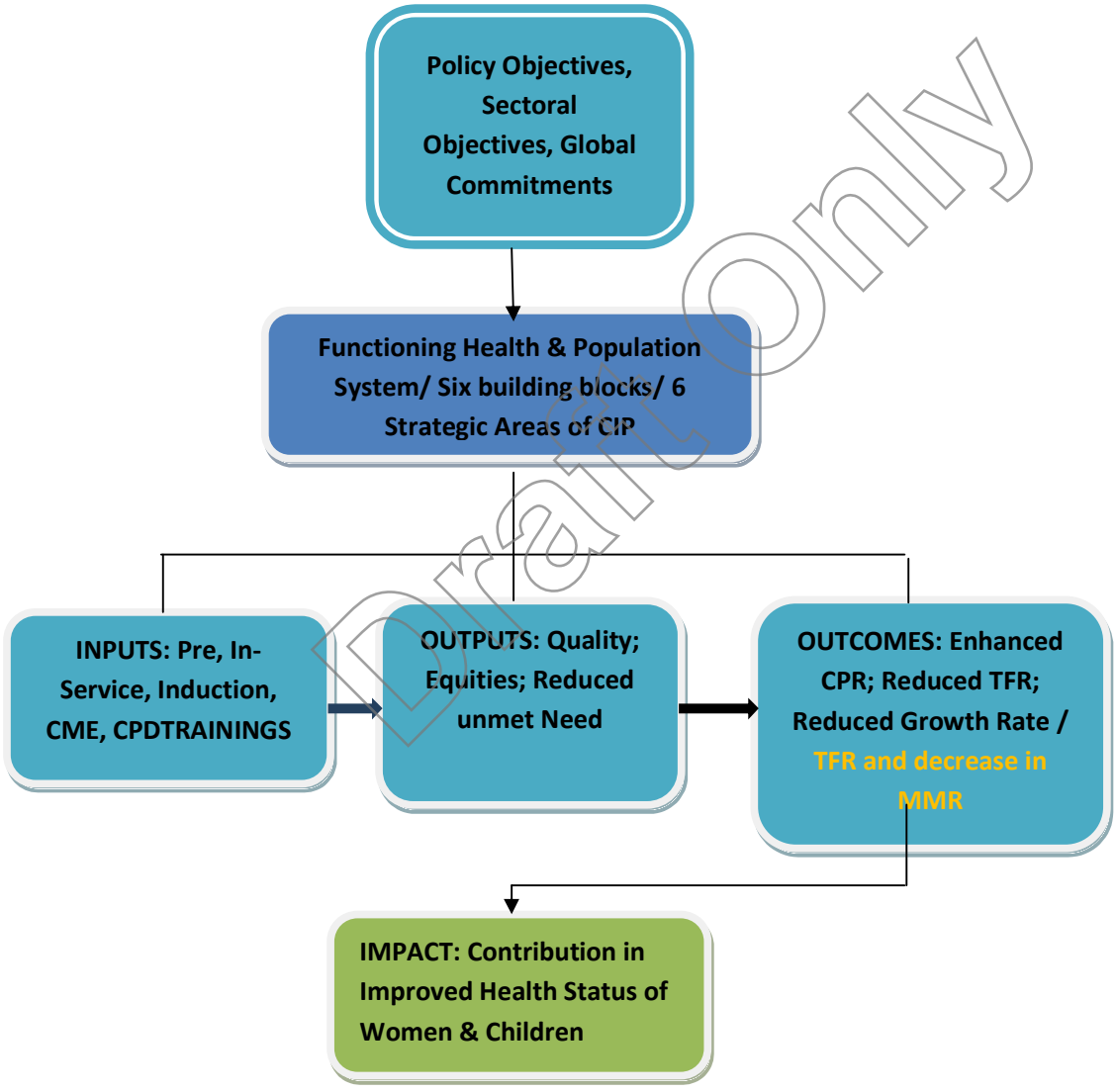
Different components of training may be emphasized like:

- Pre -Service Training
- Induction Training / Orientation
- In Service Training: On Job training, refresher
- Continuing medical Education
- Continuing Professional Development

4.2Conceptual Framework

The trainings should be part of overall health and population systems and must contribute to policy objectives and international commitments. With training inputs we intend to ensure certain outputs i.e. ensuring quality, reducing inequities (trained personnel ought to be available in rural and remote areas); reducing unmet need. We know that these outputs have potential to increase CPR; reduce fertility and reduce growth rate thus, contributing to overall impact of improved health status of mothers and children. The Conceptual Framework for the Strategy is based on this premise (Figure 4.1). As seen in the Framework, it is imperative to strengthen the health and population systems for maximum effectiveness of trainings.

Figure 4.1: Conceptual Framework



SECTION - 5 PRE & IN-SERVICE TRAINING STRATEGY

5.0 PRE & IN-SERVICE TRAINING STRATEGY

5.0 PRE&IN-SERVICETRAINING STRATEGY

The Pre and In-Service Training Strategy is fundamentally aimed at analyzing the existing training environment across population, health and development sectors; identify the challenges and recommend ways and means and strategies to initiate training processes as comprehensive and holistic approach towards career development and achieving policy objectives. It has been deliberately avoided to develop "Annual Training Plan" per se since that document is within the purview of the training institutes of health and population i.e. PWTI, RTIs PHDC, DHDCs, and Public Health Schools etc.There is no need to swap that institutional arrangement already working, however, this Strategy is aimed at strengthening that institutional mechanism. The purpose of this strategy is to recommend the strategic areas for bringing in a policy shift from the routine ways of developing Training Plans, instead those plans would be developed 'differently' with a 'new approach'. Therefore, clearly, the Annual Training Plans will be the instruments/tools to carry forward the recommendations made in this Strategy.

The Pre and In-Service Training Strategy has not been developed as two separate documents rather both sections are developed in sequence so as to emphasize that both are inter dependent and are perceived as continued process.

The Strategy is linked to policies in the health and population sectors and the CIP document. The CIP's strategic area No. 2 is dedicated to trainings and quality, therefore, this Strategy is seen as extension to the CIP with elaborated details on CIP's strategic area 2.

Following are the salient features of the draft FP training strategy comprising themes, objectives, key outputs and implementation plan.

5.1 Thematic Approaches

- Trainings are seen as a fundamental need for addressing inequities (arising due to shortage of skilled staff to take care of rural, remote areas and poor and underprivileged population groups); ensuring quality; and reducing unmet need
- Trainings need to be imparted in streamlined, horizontal manner(across the public sector, academic institutions, development sectors) in a way that pre, in service, continuing medical

education and continuing professional development are integrated for maximum individual career development as well as better population outcomes

- Trainings needto be linked with recent developments and modern techniques (task sharing/shifting etc.)

5.2Objectives

General

- To streamline the trainings so as to significantly contribute towards:
    - Enhancing CPR from existing 30% to 45% by the year 2020
    - Reducing unmet need from existing 21% to 14% by 2020
    - Delivering quality contraceptives at 80% facilities by 2018 by skilled human resources, by reducing stockouts
- To enhance competency based skills through pre-service, in service trainingsto deliver quality services on equitable basis with rights based approach
- To standardize the curriculum at pre and in-service stages within public and private sectors
- To undertake impact assessment of trainings; conduct TNA based on findings of the impact assessment; and translate those results into Annual Training Plans
- To strengthen monitoring, evaluation, supportive supervision and feedback mechanisms so that intended outcomes of trainings are ensured
- To develop career development plans for each category of staff

Pre-Service

- To include family planning components by revising existing curricula so that each related category of staff gets theoretical and practical training on method mix; counseling; rights based approach and communication skills

In-Service

- Building upon per-service training and induction training, develop an integrated training mechanism that enhances skills based on standardized curricula in continuation of pre-service training. The training would maintain balance between theoretical and practical components; would include method mix; counseling; right based approach and communication skills etc.

5.3 Reforms on Human Resource Development (HRD)

Based on the discussion in this Strategy document, training related strategies have been outlined in this section. The strategies are divided into pre & in-service training strategies. These strategies can be implemented under a broad human resource development reforms in the public and private sector. These reforms are broad guidelines to achieve the Strategy objectives and are translated into more details in the matrices. Following box provides broad human resource development reforms to be introduced in the public and private sectors:

REFORMS ON HUMAN RESOURCE DEVELOPENT (HRD)

Policy& planning

- Implementing 'Task Shifting' approach through necessary trainings starting with LHWs, CMWs, FWW and LHVs (LHWs to administer first injection while CMWs, FWW, LHVs to insert implanon
- Integration of pre & in-service trainings moving towards career development plans

Institutional

- Revamping Training related Wings, Units at PWD, DoH to enable them to deliver under new realities and challenges

Curriculum

- Introducing robust mechanism of "accreditation" by revising the existing mechanisms of certification of trainings
- Linking training courses with the system of "credit hours" and information technology
- Revising curricula at various levels specifically revision of medical curriculum to introduce family planning component in sufficient detail and mandatory exam components

Faculty

- Capacity building of faculty on new techniques of teaching and new approaches in family planning

Public Private Partnership

- Standardization of curriculum and making it uniform across the public and private sectors following the Manual on FP Standards

Monitoring & Supportive Supervision

- Emphasizing on conducting Training Need Assessments (TNA) as an in-depth exercise and develop 'Annual Training Plans' according to TNA
- Promoting research activities on human resource development (using Operational Research and Implementation Research) by each training institution and presenting the findings at various forums organized for the purpose and translating them into decision making

5.4 Pre and In Service Training Strategies

For the achievement of above mentioned objectives, following two matrices provide details on challenges; strategies to address those challenges (in terms of policy planning, institutional, curriculum, faculty, public private partnership, evaluation and supportive supervision); implementation mechanisms for these strategies; intended outputs; reflection of those strategies into the Annual Plans and roles and responsibilities.

I. PRE-SERVICE TRAINING STRATEGIES

Matrix: Pre-Service Training Strategies (2016-2020)

Challenges, Issues	Strategies to address Issues	Implementing Mechanisms	Outputs	Translating into Annual Plans	Roles and Responsibilities
Policy& Planning: i. Lack of integration of pre service training with in-service training plans	i.A comprehensive and integrated training roadmap for each staff category to be developed with milestones based on pre service and in-service aspects	i. Integration of pre and in-service trainings for each staff category to make training more effective	i. Comprehensive and integrated training road map (pre & in service)	i. Annual Plan should have two aspects pre and in-service trainings	PWTI, RTIs, PHDCs, Public Health Schools
ii.Long term career development not focused during pre -service (i.e. medical education)	ii.Career development plan to be developed for each staff category in order to take the training in holistic way keeping in view the needs of human resource	ii.Career Development to be central to the training taking into account the needs and aspirations of the human resource	ii. Career Development Plan	ii. Training Institutes to prepare plans putting human resource needs up front	
iii.Adequate resources have been an issue for educational/ training institutes	iii.Advocacy plan for enhancing resources and timely disbursement	iii. Advocate with policy makers for increase in resources for FP training	iii.Advocacy plan for implementation	iii.Costing of Plans to be carried out for advocacy with policy makers	
iv.Shift in training to include new areas i.e. Policy planning, management, Administration, operations, M&E(for non-program also)	iv.Plan to be chalked out to add new areas along with needs to cater to training on new areas	iv. To make plans for inclusion of areas like policy planning, management, operations, M&E in training	iv.Plan for inclusion of new areas into training	iv. Review of Annual Plan to incorporate training on policy, management, admin etc.	
v. Issues of access and availability of services at community level and rural	v. **Training focusing on Task Sharing/shifting aspects** Policy level	v. Revision of curriculum to add task sharing (LHWs to	v. Revised curriculum adopted with task sharing as	v. Task sharing will be made part of Annual Plan from	

areas	decision taken to decide modalities of task sharing	administer first injection; CMW, LHV, FWW to insert implanon under supervision, DoH staff to work on counseling)	its part	2016	
vi. Accreditation of training process and trainees	vi. Formulating a team of experts to suggest a framework for accreditation	vi. Consultations with different existing accreditation bodies	vi. Accreditation of training Framework developed	vi. Accreditation of training made part of each Annual Plan	
vii. Lack of information on pre service training institutions and courses that hinders any required interventions	vii. **Mapping of pre-service training institutes required**	vii. Organize a meeting of stakeholders (HEC, PNC, PMA, PMDC and others) to decide on mapping and next steps	vii. Mapping exercise Report	vii. Translating into Plans of relevant organizations	vii. HEC/Medical Universities, PNC, PMDC and other
Institutional: i. Facultyrequires refreshers (PHDC/RTI, PWTI, PHS)	i. Besides refreshers through routine channels, innovative ways to have refreshers for faculty in cost effective manner i.e. refreshers undertaken by seniors for juniors; sister organizations may be requested to help conducting refreshers	i.Principal/Head of a institute to coordinate with other organizations and arrange	i.Refreshers held	i.Refreshers by seniors for juniors and sister organizations reflected in Annual Plan	i.Principal/Head of Institute
ii. Issues related to limited budget available for training institutes i.e. PHDC etc.	ii. Advocacy plan for enhancing resources and timely disbursement	ii.Principal/Head to undertake meetings with the Department and make briefings for	ii.advocacy meetings for funding held at PWD/DoH/DoF/P&D	ii.Meetings with policy makers reflected in Annual Plan	ii.PWTI, RTI, PHDC, Public HealthSchool (PHS)

iii.Capacity building of faculty/master trainers	iii.A separate components in Annual Plan of each Institute with dedicated resource	the DoF/P&D iii.Collaborating with various institutes in public and private sector to enhance capabilities of master trainers/faculty	iii.Reports on refresher trainings conducted	iii. Reflected in Annual Plans	iii.PWTI, RTIs, PHDC
iv.No or less opportunities for research in Training Institutes	iv.Collaboration with universities, research organizations and INGOs on research activities	iv.Dedicating human and financial resources in Annual Plans	iv. Research reports	iv.Reflected in Annual Plans	iv.PWTI, RTIs, PHDCs
institutions not or less linked with modern technologies (e-learning, web based knowledge management, webinars)	v.collaboration with various training and research centers/IT companies to utilize modern technologies	v.Meetings with mentioned organizations to develop way forward	v. Plan on use of modern technology	v.Annual Plan	v.PWTI, RTI,PHDC etc.
Curriculum: i.Need to standardize curriculum of various cadres across the public and private sectors and addition of new knowledge – adding rights based approach ii. Lack of balance between theory and practice; skill	i. Formation of an expert team to review and suggest standardization of curriculum (development partners may facilitate); along with rights based approach; various curriculum prepared by partners to be discussed; HEC/PNC accreditation needed ii. Revision of time	i.PTCC to approve standardization protocols on curriculum ii.Consultation between PWD, DoH, PPHI, development partners to develop mechanisms	i. Decision of PTCC on standardization approved by competent authority ii.Mechanism on balance between theory and practice in the curriculum	i. Annual Training Plan to add standardized curriculum ii.Annual plans revised accordingly	PWTI, TRI, PHDC, PHS, partners ii.PWD, DoH, PPHI, LHW, MNCH

development; and competencies.Curriculum skewed towards theoretical aspect, i.e. CMW curriculum to be extended from 18 months to 2 years etc. iii.One of the missing areas in LHWs/CMW/LHV/FWW course is referral of FP/MCH cases and other skills i.e. record keeping. Likewise, counseling and all methods not included iv. Negligible FP related training opportunities for MOs/WMOs (medical students) during their pre-service training. Due to non-utilization of skills acquired after training, the knowledge level deteriorates	duration of training and curriculum for creating balance in theoretical and practical aspects besides enhancing FP modules iii.At least one month pre service theoretical training for LHWs on counseling, communication/IPC, referral, contraception etc**.** Same required for CMWs, LHVs, Nurses Revision of curricula as per each cadre iv. Consultations with medical colleges, institutes to develop training modules (mandatory FP exam stations during Obgyn exam)	to create balance and suggest support mechanisms to implement iii.Team to revise curriculum iv. RHS and other FP related facilities to support in training as per training modules	iii.LHWs, CMWs, LHVs, Nurses' revised curriculum available iv. Training modules for medical students	iii. Areas added into Annual Plans iv. Medical colleges curriculum revised and new modules added	
Trainers/Faculty: i. Training of faculty needed	i.Refreshers be made part of Annual Plans by ensuring funds, master trainers, supplies	i. Arrangement be discussed at institutional level. Refreshers are due, last	ii.Refresher schedule	i.Refreshers made part of annual plan	i.Educational Institutes/ Education Department, PWTI,RTIs

	etc.After every 2 years, refreshers required	held in 2013			
ii. Shortage of faculty trained in FP at pre service level	ii.Pooling faculty resource between PWD and Health sectors	ii.Meeting to discuss the possibilities of pooling in resources	ii.Minutes of the meeting/decision	ii.Resource pooling in reflected in sectoral plans	ii.PWD, DoH, other relevant stakeholders
Evaluation and Supportive Supervision of FP component in Medical education / staff training: i. Trainings are rarely evaluated for their effectiveness and keeping pace with modern knowledge and technologies	i. All trainings would be periodically evaluated (in house and third party) beside a mechanism of supportive supervision will be put in place at institutional level	i. Development partners will be consulted to design and initiate the process of evaluation and supportive supervision	i. An evaluation plan developed	i. Evaluation and supportive supervision part of planning	i.Educational institutions and training institutes, partners

II. IN-SERVICE TRAINING STRATEGIES

Matrix: In-Service Training Strategies (2016-2020)

Challenges Issues	Strategies to address issues	Implementing mechanisms	Outputs	Translating into Annual Plans	Roles and Responsibilities
Policy& Planning:				-	
i. Lack of systematic linkages between pre & post-service training plans	i. An streamlined training roadmap for each staff category to be developed for pre-service and in-service aspects as a continuum of capacity building model (Annexure …. Trainings list for each staff category)	i. Advocacy required for a policy shift	i. Policy briefs		i.Intersectoral efforts required i.e.population, health, education (through P&D)
ii.Long term career development not focused during in-service	ii.There lacks career plan that would show what training steps will be followed during the career of a human resource. Dedicated Unit/ Focal Point/ Cell at departments to develop a career plan (DoH developed its HR strategy)	ii.Career Plan should reflect training needs required on annual basis	ii. Individual Career Plans	ii.Annual Plan may provide yearly details about individual HR professional development during his/her career	ii.PWD, DoH, PPHI, partners
iii.Quality of services is compromised due to lack of proper training	iii.Quality of services to be ensured through timely refreshers, equipment, training faculty	iii.Refreshers organized with proper back up support of equipment so that quality is ensured; trainings would be linked to promotions	iii.Refreshers in timely fashion	iii. Annual Plan to ensure that refreshers are planned in a way that these can be implemented	
iv.Before focusing on skills	iv.Development of a Human		iv.HR Strategy		iv.PWD, DoH, PWTI, RTIs, PHDC,

of human resources to address quality and equity issues there is needed to assess the available human resources in health and population sectors from perspective of their needs. v. Shift in training to include new areas i.e. Policy, management, Administration, operations, M&E (for non-program trainees also)	Resource Strategy or a Needs Assessment would be required for identifying capacity needs v. Plan to be chalked out to add new areas along with needs to cater to training on new areas	iv.Assigning dedicated team to develop the HR strategy v. To make plans for inclusion of areas like policy planning, management, operations, M&E in training	v.Plan on inclusion of new areas in the trainings	iv.Annual Plan includes action points from HR strategy v. Review of Annual Plan to incorporate training on policy, management, admin etc.	development partners v. PWD, DoH, PWTI, PDHC
Institutional: i.Faculty requires refreshers so as to provide training on both theory and practical/ hands on	i.Innovative ways to have refreshers for faculty in cost effective manner i.e. refreshers undertaken by seniors for juniors; sister organizations may be requested to help conducting refreshers	i.Principal/Head of a institute to coordinate with other organizations and arrange	i.Refreshers held	i.Refreshers by seniors for juniors and sister organizations reflected in Annual Plan	i.Principal/Head of Institute
ii. Issues related to limited budget available for training institutes	ii. Advocacy plan for enhancing resources and timely disbursement	ii.Secretary/ Principal/Head to hold meetings with the Department of Finance (DoF) and P&D	ii.advocacy meetings for funding held at PWD/DoH/DoF/P&D	ii.Meetings with policy makers reflected in Annual Plan	ii.PWTI, RTI, PHDC, Public Health School (PHS)
iii.No or less opportunities for research in Training	iv.Collaboration with universities, research	iv.Dedicating human and financial resources in	iv. Research reports	iv.Reflected in Annual Plans	iv.PWTI, RTIs,

Institutes **iv.Institutions not or less linked with modern technologies (e-learning, web based knowledge management, webinars)**	organizations and INGOs on research activities v.collaboration with various training and research centers/IT companies to utilize modern technologies	Annual Plans v.Meetings with mentioned organizations to develop way forward	 v. Plan on use of modern technology	 v.Annual Plan	PHDCs v.PWTI, RTI,PHDC etc.
Curriculum: i.Need to standardize curriculum across the public and private sectors and addition of new knowledge and right based approach ii. Lack of balance between theory and practice, curriculum skewed towards theoretical aspect, i.e. CMW curriculum to be extended from 18 months to 2 years and focus on skills and competencies	 i. Formation of an expert team to review and suggest standardization of curriculum (various curriculum prepared by partners to be discussed; HEC/PNC accreditation needed) – adding elements of rights based approach ii. Revision of time duration of training and curriculum for creating balance in theoretical and practical aspects; revision curriculum for inclusion of all methods as well as counseling	 i.PTCC to approve standardization protocols on curriculum ii.Consultation between PWD, DoH, PPHI, development partners to develop mechanisms to create balance and suggest support mechanisms to implement; Training of trainers Pre and In service 15 days mandatory training at RHS A / RTIs (theory + hands on) Paramedic 3 months	 i. Decision of PTCC on standardization approved by competent authority ii.Mechanism on balance between theory and practice in the curriculum	 i. Annual Training Plan to add standardized curriculum ii.Annual plans revised accordingly	 i.PWTI, TRI, PHDC, PHS

iii.One of the missing areas in LHWs/ CMW/LHV/FWW course is referral of FP/MCH cases and other skills i.e. record keeping. Likewise, counseling and all methods not included iv. Negligible FP related training opportunities for MOs/WMOs during their per service training	iii. At least one month pre service theoretical training for LHWs on counseling, communication/IPC, referral, contraception etc. Same required for CMWs, LHVs, Nurses iv. Consultations with medical colleges, institutes to develop training modules	Evaluation of trainers and trainees iii.Team to revise curriculum iv. RHS and other FP related facilities to support in training as per training modules	iii.LHWs, CMWs, LHVs, Nurses' revised curriculum available iv. Training modules for medical students	iii. Areas added into Annual Plans iv. Medical colleges curriculum revised and new modules added	
Trainers/Faculty: i. Shortage of training staff due to long standing ban on recruitments; sanctioned positions not sufficient (also staff not posted as per number of sanctioned posts) due to increasing volume for trainings	i.The issue may be resolved in short term through inviting visiting faculty or development partners may fund crucial positions as a stopgap arrangement also through pooling-in faculty resource between PWD and Health sectors/ advocating for more resources and relaxation of rules	i.PWTI, RTIs, PHDCs, PHSs may present details to the parent department that may present the case to Finance, P&D. A separate dialogue may be held with potential donors. PWD's RHS doctors may train MO BHU since he/she is responsible to train LHWs	i.Summary for Finance and P&D i.A proposal for donors	i.Once arrangements are made the details may be incorporated into Annual Plans	i.PWD, DoH, PWTI,RTI,PHS

ii.Mechanism for induction trainings and refreshers is lacking	ii.Refreshers be made part of Annual Plans by ensuring funds, master trainers, supplies etc. After every 2 years, refreshers required; Induction training plans to be developed	on FP ii.Arrangementsbe discussed at department level. Refreshers are due after last held in 2013, newly trained would work under supervision for 3 months	ii.Refresher& induction training schedule	ii.Refreshers for faculty / trainers made part of Annual plans	ii.PWD, DoH, PWTI, RTIs, PHSs
Public Private Partnership in Trainings: i. Need to standardize the training protocols, curriculum across the partners i.e. public and private sectors, NGOs etc. Although some trainings for private sector are conducted by PWD	i. Consultations to be organized for making curriculum across partners uniform and standardized as per National Standards on FP	i. Development partners to be requested to facilitate the process (USAID/Palladium/ UNFPA); a joint committee to work on standardized curriculum, protocols etc.	i.Plan for standardization of curricula	-	i.PWD, DoH, Development Partners
ii.Need to align development partners' capacity building activities – national and international (undertaken for the public sector) with overall training plans/Strategy	ii.Development partners usually invite public sector officials for national and international trainings/ some courses take place at private universities (AKU, HSA), most of the time these remain one time activities and are rarely utilized afterwards within the sector. Development of a capacity building coordination plan through mutual consultations	ii.Consultations to be organized with partners to develop a plan well integrated with Departments' capacity needs (USAID/Palladium/ UNFPA)	ii.Capacity development plan	ii.Broad ideas reflected in Department's annual work plans	ii.PWD, DoH, PPHI, Development partners

Evaluation and Supportive Supervision of FP component in Medical education / staff training:					
i. Trainings are rarely evaluated for their effectiveness, impact and keeping pace with modern knowledge and technologies (qualitative data may also be made part of assessments)	i. All trainings would be periodically evaluated (in house and third party)	i.Development partners will be consulted to design and initiate the process of evaluation and supportive supervision	i.An evaluation plan developed	i. Evaluation and supportive supervision part of planning	i.Educational institutions and training institutes, partners
ii. Trainings are not monitored or followed up for intended outcomes; supportive supervision also lacks	ii.Trained staff will be provided supportive supervision for few months unless they attain considerable level of experience.	ii.Annual Plans to include M&E and supportive supervision funds	ii. M&E and supportive supervision plan	ii.M&E/supervision included into Annual Plan	ii.PWTI, RTI,PHDC,PHS etc.
iii.Trainings are not standardized within different sectors as well as from quality perspective	iii. Develop a plan to introduce mechanism of "credit hours" so as to make the trainings comparable across the sectors and institutions	iii.Discussions with various stakeholders to introduce 'credit hours'	iii.Mechanism for 'credit hours'	iii.Annual Plan includes new mechanism	iii. PWTI, RTI,PHDC,PHS etc.

Annexure - I

Table: PWD: Types of Facilities; FP Services; Types and numbers of Staff

Type of Facilities	Number of Facilities	Types of HR	Number of HR	Services offered
Provincial, Regional and District Offices				
Head office	01	Senior level and Management	143	Policy, management, Administration
Regional Directorate	06	Management	36	management, Administration, operations
District office	29		667	Administration, operations, M&E
Taluka office	86	Management	258	Administration, operations, M&E
Service Delivery Outlets				
RHS A Centers	30	FP services, admin	792	LARC, permanent methods, short term methods
Family Welfare Centers (FWCs)	961	FP services, admin	5880	IUCD, short term methods
MSUs	72	FP services, admin	288	LARC, permanent methods, short term methods
Social Mobilizers (Male)		Awareness	1250	
Social Mobilizers (Female)		Awareness	1102	
MPSB	01	FP services, admin; socio-economic services	11	LARC, permanent methods, short term methods
Sub Total (Service Delivery)	**1,064**		9,323	
Training Institutes				
PWTI	01	Trainings for Non program	22	To conduct refresher course for program personnel Creating awareness about small family norms for general public
RTIs	04	Trainings for FP methods,	148	
Grand Total for HR			**10,597**	

Source: Population Welfare Department, Government of Sindh

Annexure – II

Table :DoH/PPHI: Types of Facilities, FP Services, Types and numbers of Staff

Type of Facilities	Number of Facilities	Types of HR	Number of HR	Services offered
Provincial, District Offices				
Provincial office	01	Senior level Management		Policy, management, Administration
Directorate Health Services	01	Senior level Management		management, Administration, operations
District offices	30	Midlevel Management		Administration, operations, M&E
Taluka office		Midlevel Management		Administration, operations, M&E
Service Delivery Outlets				
District Headquarter Hospitals	18	FP services, admin		LARC, permanent methods, short term methods
Taluka Headquarter Hospitals (THQs)	44	FP services, admin		IUCD, short term methods
Rural Health Centers (RHCs)	125	FP services, admin		LARC, permanent methods, short term methods
Basic Health Units (BHUs) - PPHI	783	Awareness		
LHWs		Awareness	22575	
LHS		FP services, admin; socio-economic services	770	LARC, permanent methods, short term methods
LHVs			894	
CMWs			1705	
Training Institutes				
Medical Colleges	21 (9 public, 12 private)		142 (average in public sector medical college)	
General Nursing Institutes	57 (including			

	37 CMW Institutes)			
PHDCs	01	Trainings for Non program	22	Training and research on all public health issues including FP.
DHDCs	44	Trainings for FP methods,	148	Training and research on all public health issues including FP.
Public Health Schools for LHVs	05			
Grand Total for HR			10,597	

Source: Department of Health; HRH Strategy; LHWs, MNCH, PPHI programs, Govt. of Sindh